

The Medicare Managed Care Choice

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MEDICARE

The Medicare Managed Care Choice

Medicare managed care still has problems and careful evaluation is critical when choosing a program. Government attempts at providing information have created further confusion and drawn criticism from the professionals. This overview highlights some of the most important issues.

By Journal Staff

In November 1998, Medicare beneficiaries around the country received a seven-page bulletin "Medicare and You" from the Department of Health and Human Services (DHHS) apprising them of their opportunity to choose managed care in lieu of traditional Part A/Part B coverage. The initiative comes in response to the 1997 enactment of Medicare+Choice (the long anticipated "Medicare Part C"), but attempts to deal with current service options.

Somewhat belated for some beneficiaries, the one-size-fits-all notice was sharply criticized for failure to emphasize that no change is required. In fact, the catalog of options is not available to Medicare beneficiaries in many localities, mostly rural areas, where no provider has signed a contract with DHHS to provide specific expanded services. Indeed, some areas still have no Medicare HMO at all. Further, it does not clearly state that a beneficiary who chooses Medicare managed care gives up traditional coverage.

Elder law attorneys heard from their clients—or proactively sent a reassuring explanation: *No change is necessary. Change may not be wise for many.* The reasons have to do with managed care generally and with Medicare managed care in particular.

The Track Record for Medicare Managed Care

The federal government was an innovator in managed care in the early eighties, anticipating the growing use of cost constraints and prospective payments in employee benefits. The model came too little and too early, however. Contracting providers were restricted from offering many of the benefits beneficiaries wished Medicare provided, such a prescription drug coverage, and administrative requirements were daunting for the era. In addition, some HMOs—especially in sunbelt locations, which held the lure of a great volume of patients—engaged in widespread fraud, signing up reluctant people on the street, maintaining enrollees on the records

after their deaths, and even enrolling individuals listed in the obituaries. Perhaps more important for current times, more reputable providers found profits elusive and dropped out. The proportion of Medicare managed care enrollees topped out at less than 4 percent, and the government withdrew its support for the concept.

Medicare HMOs have a renewed impetus in the mid-1990s. Managed care providers who enjoyed their growth in the private employee benefits market have looked to Medicare for new markets. Current contracts are similar to private sector contracts in that they provide for a set fee per beneficiary per month, thereby spreading the risk of the need for high-cost care to the provider organization. By mid 1998, about 16 percent of Medicare beneficiaries had opted for HMO coverage, and the number is growing as new providers and regions offer the option. Managed care provides federal policy analysts with the hope of controlling and accurately predicting costs in order to keep the Hospital Insurance Trust Fund solvent and contain Part B premiums and the need for general revenues subsidies.

Why Join a Medicare HMO?

Medicare beneficiaries who choose HMO care generally receive a broader package of benefits than are provided by traditional Part A and B coverage, including such preventive care services as routine physicals, eye and hearing exams, and immunizations. Over half of HMOs offer some coverage for

prescription drugs for an optional premium. Prescription drug costs is the most frequently cited reason clients switch to HMO coverage.

Beneficiaries pay the Part B premium and possibly a surcharge to the HMO for costly extra benefits. However, care management is expected to lower the cost of the total package of benefits and eliminates the need for Medigap insurance. Medicare HMOs do *not*, however, provide long-term care.

The Potential Betrayal of HMO Coverage for the Elderly

Two principal problems loom ahead for some Medicare beneficiaries. Both are based in the managed care cost-containment strategy: shifting the risk of high-cost care to the provider, who must take steps to control the utilization of high-cost services or become unprofitable.

Among the care management strategies common to HMOs, three are significant impediments to good care for elders.

Geographic Restrictions

Most HMOs require that beneficiaries receive all care except emergency services from designated providers in the region. The pattern is essential to projections for the profile of potential enrollees and to negotiating contracts with providers that assure a "captive market" of patients. Only a limited number of providers have attempted the difficulties of serving the considerable population that migrates by season. Thus, an HMO is seldom appropriate for "snowbird" migrating retirees.

Similarly, frequent travelers will have significant problems with coverage if an enrollee becomes ill while away from home. All HMOs are required to cover emergency care provided anywhere by any appropriate and qualified provider, but managed care organizations have placed prior approval road blocks that, at best, delay the delivery of care. Recent federal legislation has been enacted to require that all HMOs apply the "prudent layman rule" with regard to payments for emergency care at home or elsewhere, but no track record of compliance assures the individual patient will benefit consistently.

Specialist Care and Chronic Illness

Most managed care providers require patients to undergo screening by a primary care provider or other "gatekeeper" before receiving care from a specialist. Such gatekeeping is very burdensome for a patient with a chronic condition and may result in inappropriate care if specialist services are denied. For example, an individual with severe rheumatoid arthritis might be approved to consult a specialist for pain and care of the specific condition. Given that chronic conditions often affect the individual's overall health and response to treatment, useful specialist care might be denied when the patient seeks treatment for an ordinary illness such as the flu. The primary care provider might not appropriately take into account the severity of and the impact of treatment for the chronic condition and provide ineffective or harmful

care for the transitory condition. Only a few HMOs have provisions for recognizing patients with compromising chronic conditions as eligible to receive all care from a designated specialist.

Beneficiaries who travel frequently or regularly, or who have ongoing needs for specialist care are well advised to stick with traditional Medicare coverage.

Prescription Drug Restrictions

Many HMOs have arrangements with drug companies to utilize specific, sometimes generic, forms of drugs. Though such drugs are generally considered to be equivalents, many people experience great differences in drug potency or side effects. Side effects and dosages are very important to elderly and ill beneficiaries. If the patient must have a drug the HMO does not generally provide, the patient's cost and/or hassle factor increases.

In a few states, HMOs are required to provide an administrative process by which physicians can request drugs not on the approved list for patients who need them. However, all such legislation is quite new, and its effectiveness is untested.

Other Problems Affecting Continuity of Coverage

Underestimating the Cost of Care

Often, initial premiums are set too low for pay costs. Upon

entering the Medicare market, most HMOs set premiums lower than projected costs to attract enrollees. The failure of HMOs in 1998 is due at least in part to the very low premiums charged to enter the market. At the least, enrollees face a rise in premiums in the first five years. At worst, the HMO will withdraw from the market leaving enrollees to readjust to traditional Parts A and B. Premiums no higher than the Part B premium are suspect, since the HMO bears the risk (generally about 30 percent of costs) borne by the government with traditional Medicare coverage. Coverage with prescription benefits and preventive care require premiums exceeding \$125 per month in 1998.

The HMO Withdraws from the Market

A number of HMOs cannot make a profit in the Medicare market, as shown by the first wave of withdrawals from contracts on January 1, 1999. The providers most likely to end Medicare coverage are in rural areas where there are too many Medicare enrollees and too few younger and healthier individuals. Those who set the initial premium too low are also at risk.

Beneficiaries can return to traditional coverage if their HMO is no longer available. However, beneficiaries with significant needs particularly for prescription drugs usually can-

not restore their Medigap coverage with drug coverage.

Medicare HMO beneficiaries are entitled to receive Medigap coverage, but are restricted to certain basic policies that do not include drugs. Insurers can deny other coverage or require payment of very high premiums.

Generally, any beneficiary is well advised to maintain Medigap coverage during the first interactions with a new HMO provider. It is far more difficult to predict the time the HMO may end its contract. It is better to anticipate the potentially unstable HMO contract and forego HMO coverage unless there are strong indicators that the HMO is a long-term and successful participant in health care in the area.

The Future of Medicare's Managed Care Choices

The federal government is testing the expansion of managed care, and information about managed care, in five states: Arizona, Florida, Ohio, Oregon, and Washington, where beneficiaries have received the 36-page book that expands on managed care and Medicare+Choice. The book has attracted criticisms similar to those of the nationwide bulletin and will be revised. Meanwhile, insurance companies and advocates are sending out information representing their own perspectives.